BENEFITS AT A GLANCE

This section of *Your King County Benefits* highlights the major features of your benefits for easy reference. More detailed information is available in the individual plan sections.

In This Section — See Page

HEALTH CARE

As a King County employee who's eligible for benefits, you receive medical (including prescription drug), dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and dependent children) you enroll.

Participating in the Health Care Plans

To effectively use the health care plans, you need to know who's eligible for coverage, when and how to enroll, when you can make changes, who pays for coverage, when coverage begins and ends, and when you can continue coverage.

Who's Eligible

As a part-time transit operator or an assigned or on-call employee represented by Local 587, you're eligible for one of two health care plans:

- Partial Benefits Plan; or
- Full Benefits Plan.

You become eligible for the Partial Benefits Plan on the first day of the month following your hire date or qualification date, whichever is later. Under the Partial Benefits Plan, you may purchase medical, dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and dependent children) you enroll.

Eligibility for the Full Benefits Plan is determined by an agreement between King County and Amalgamated Transit Union Local 587 based on working the required number of hours. Under the Full Benefits Plan, you receive county-paid medical, dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and children) you enroll.

When and How to Enroll

You receive enrollment materials for the Partial Benefits Plan and the Full Benefits Plan once you become eligible.

Partial Benefits Plan

When you first become eligible for benefits as a part-time transit operator, you receive enrollment materials in a Part-Time Local 587 New Hire Guide and wellness assessments for you and your spouse/domestic partner at a benefits orientation during your part-time transit operator training.

You must submit your benefit enrollment forms for the Partial Benefits Plan **within 30 days of your hire date or qualification date, whichever is later.** If you don't submit your enrollment forms within 30 days, you must wait until the next annual open enrollment to enroll in the Partial Benefits Plan.

FOR MORE INFORMATION

For more detailed information about participating in King County's health care plans, see "Participating in the Health Care Plans" in *Health Care*.

In addition to returning your enrollment forms, you and your spouse/domestic partner must each decide whether to take the wellness assessment if you're planning to enroll for medical benefits. You and your spouse/domestic partner, if he/she will receive county medical benefits, will have **14 days from the day you receive your benefits orientation during training** to take the wellness assessment and return it.

If you aren't planning to enroll in the county's medical coverage, you and your spouse/domestic partner will be given the opportunity to take the wellness assessment later, when you either sign up for medical coverage during an annual open enrollment or become eligible for the Full Benefits Plan.

Full Benefits Plan

You must submit your benefit enrollment forms for the Full Benefits Plan by the deadline indicated in your Full Benefits Plan materials, which are mailed to you before you're eligible for the Full Benefits Plan. If you don't submit your enrollment forms by the deadline:

- only eligible dependents you've previously enrolled in a King County medical plan will be covered;
- you'll be assigned KingCare℠ as your default medical coverage at the out-of-pocket expense level you and your spouse/domestic partner have most recently achieved by your participation in the Healthy Incentives℠ program; and
- you'll have to wait until the next annual open enrollment to change your medical plan.

If you don't enroll when you're first eligible, you may enroll yourself and your eligible dependents during the annual open enrollment.

When You Can Change Coverage

You may make certain changes to your health care coverage during the county's annual open enrollment and after certain qualifying life events—for example, you may add an eligible dependent if you get married or have a child.

In addition, you may discontinue coverage for your eligible dependents at any time. However, if you're in the Partial Benefits Plan and your premiums are deducted on a before-tax basis, you may not discontinue health care coverage until the next annual open enrollment unless you have a qualifying life event.

Who Pays for Coverage

If you're in the Full Benefits Plan, the county pays the entire premium for medical, dental and vision coverage for you and the eligible dependents you enroll. However, you pay a benefit access fee of $35 a month if you cover a spouse/domestic partner who has access to medical care coverage through an employer other than King County, a union trust paid by an employer, or the military while in active duty status.

If you're in the Partial Benefits Plan, you pay a portion of the premium for your own medical, dental and vision coverage and the full premium for coverage of your spouse/domestic partner and your eligible dependent children.

When Coverage Begins

When you enroll in the Partial Benefits Plan, coverage begins on the first day of the month following your hire date or qualification date, whichever is later. If the later of your hire date or qualification date is the first day of the month, then your benefit coverage begins the same day.

When you enroll in the Full Benefits Plan, the date your coverage begins is:

- the first day of the month after you begin the work assignment of four or more hours that qualified you for the Full Benefits Plan; or
- the first day of the following year if you work 1,019 or more paid hours in the 26 pay periods ending with the pay period that includes July 31 in 2007, 2008 or 2009.

Your eligibility for the Full Benefits Plan is determined by an agreement between King County and Amalgamated Transit Union Local 587. When you're eligible, your coverage extends through December 31, 2009.

If you're hospitalized under another benefit plan and you're in the hospital on the day county coverage would normally begin, the other plan usually continues to provide your coverage until you're discharged.

When you change coverage during the annual open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible, unless you qualify for the Full Benefits Plan.

When you return from an unpaid leave of absence, your coverage resumes on the first day of the month following your return. If you return on the first calendar day of the month, your coverage resumes the same day.

When You Can Change Coverage

You may make certain changes to your health care coverage during the county's annual open enrollment and after certain qualifying life events—for example, you may add an eligible dependent if you get married or have a child.

You must discontinue health care coverage for a dependent who is no longer eligible, such as a child who turns 23.

There are a number of changes you may make to your health care coverage at any time: you may discontinue coverage for your eligible dependents, and you may discontinue or reduce coverage you pay for.

If you're in the Partial Benefits Plan and your premiums are deducted on a before-tax basis, however, you may not discontinue health care coverage until the next annual open enrollment unless you have a qualifying life event.

When Coverage Ends

Your health care coverage ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

Health care coverage for your covered dependents ends on:

- the last day of the month they lose eligibility, your coverage ends, you fail to make any required payments for their coverage or they die; or
- the day the plan terminates.

How to Continue Coverage

If you or your eligible dependents lose county-paid health care coverage due to certain qualifying life events, each of you has an independent right to continue medical, dental and vision coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act). This coverage, which is entirely paid by you, may continue for 18 to 36 months after county-paid coverage ends.

Medical Plans

The county offers benefit-eligible employees a choice between two medical plans:

- KingCare℠, a preferred provider plan; and
- Group Health, a health maintenance organization.

How KingCare℠ Works

When you're enrolled in KingCare℠, you may receive benefits from network or out-of-network providers. The level of benefits you receive depends on the provider you choose. You pay less when you go to network providers than when you see providers who aren't part of the network.

When you go to network providers, you first pay an annual deductible; after that you pay coinsurance on a portion of the contracted cost.

FOR MORE INFORMATION

For more information about how the county's medical plans work, see "KingCare℠" and "Group Health" in *Health Care*.

Reimbursement for out-of-network medical care is based on reasonable and customary (R&C) rates. You pay the annual deductible, the coinsurance and any amounts over R&C rates.

You may purchase prescription drugs at retail pharmacies or through the mail-order service.

Medical benefits under KingCare℠ are administered by Aetna. Prescription benefits under the plan are administered by Express Scripts. You receive a medical ID card from Aetna for your medical coverage and a separate ID card from Express Scripts for your prescription drug coverage.

How to File a Claim

If you receive care from Aetna network providers, they submit claims for you. If you receive care from an out-of-network provider, your provider may submit a claim for you, or you may have to pay the provider in full and submit a claim to Aetna for reimbursement of R&C charges.

When you go to an Express Scripts network pharmacy, there's no claim to file. However, if you fill a prescription at an out-of-network pharmacy, you're responsible for paying the pharmacy in full and submitting a claim to Express Scripts, which will reimburse you at the negotiated rate within its network.

How Group Health Works

When you're enrolled in Group Health, you'll receive benefits if you see your primary care physician or another provider within the Group Health network. If you see a provider who isn't part of the network, you'll receive benefits only if you need emergency care or your network provider refers you to an out-of-network provider.

When you receive care from a network provider, you pay a flat amount, called a copay, at the time you receive health care services or fill prescriptions. After the copay, Group Health pays 100% for most covered services and supplies.

Medical and prescription drug benefits under Group Health are administered by Group Health. You receive a single ID card from Group Health for both your medical and prescription drug coverage.

How to File a Claim

If you receive care from a network provider, the provider submits claims for you. If you receive emergency services from an out-of-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you.

FOR MORE INFORMATION

For more information about how the dental plan works, see "Dental Plan" in *Health Care*.

Dental Plan

The county offers benefit-eligible employees a dental plan through Washington Dental Service (WDS), a member of the Delta Dental Plans Association.

How the Dental Plan Works

When you're enrolled in the dental plan, you may receive benefits from WDS/Delta Dental participating dentists or from non-participating dentists. The level of benefits you receive depends on the dentist you choose. You usually pay less when you go to a WDS/Delta Dental participating dentist than when you see a non-participating dentist.

When you go to a WDS/Delta Dental participating dentist, you first pay an annual deductible, if applicable; then you pay coinsurance based on the rates that WDS pays participating dentists. When you go to a non-participating dentist, WDS reimburses you based on what it pays WDS/Delta Dental participating dentists, and you're responsible for paying any remaining amount.

You don't receive an ID card for your dental plan. You'll need to tell your dentist you're covered by the WDS plan for King County. You must provide the plan's group number (00152) and either your Social Security number or a unique identifier (if you've requested one) for verification of your benefit eligibility.

How to File a Claim

If you receive care from a WDS/Delta Dental participating dentist, the dentist submits claims for you and obtains any necessary predetermination for certain procedures and services.

If you receive care from a non-participating dentist, your provider may submit claims for you, or you may have to pay the dentist in full and submit a claim to WDS for reimbursement. In addition, you must obtain predetermination from WDS for certain procedures and services.

FOR MORE INFORMATION

For more information about how the vision plan works, see "Vision Plan" in *Health Care*.

Vision Plan

The county offers benefit-eligible employees a vision plan through Vision Service Plan (VSP).

How the Vision Plan Works

When you're enrolled in the vision plan, you may receive eye care benefits from VSP providers or non-VSP providers. The level of benefits you receive depends on the provider you choose. You usually pay less when you go to a VSP provider than when you see a non-VSP provider.

When you go to a VSP provider, you pay a $10 copay when you meet with the provider, and the plan pays 100% for most covered services. When you go to a non-VSP provider, you'll pay the bill in full, and VSP will reimburse you up to the plan allowance for each service, minus a $10 copay.

You don't receive an ID card for your vision plan. You'll need to tell your eye care provider you're covered by the VSP plan for King County. You must provide the employee's Social Security number (or alternate ID if one has been requested) for verification of your eligibility.

How to File a Claim

If you receive care from a VSP provider, the provider will handle all your claims.

If you receive care from a non-VSP provider, you'll have to submit claims to VSP for reimbursement.

FLEXIBLE SPENDING ACCOUNTS

As a King County employee who's eligible for benefits, you may be eligible to enroll in either a health care flexible spending account (FSA) or a dependent care FSA, or both.

Participating in FSAs

To effectively use FSAs, you need to know who's eligible to participate, when and how to enroll, when you can make changes, when participation begins and ends, and when you can continue participation.

Who's Eligible

You're eligible to participate in an FSA when you first become eligible for benefits, have a qualifying life event or enroll in an FSA during the annual open enrollment.

You're eligible for benefits if you're a part-time transit operator or an assigned or on-call employee represented by Local 587 in either the Partial Benefits Plan or Full Benefits Plan.

When and How to Enroll

You receive FSA information and a Flexible Spending Account Enrollment form when you first become eligible for benefits. You must return your enrollment form to Benefits and Retirement Operations within 30 days of your benefit-eligibility date. Your benefit-eligibility date is the day you first report to work or the day you qualify as a part-time transit operator, whichever is later.

FOR MORE INFORMATION

For more detailed information about participating in FSAs, see "Participating in FSAs" in *Flexible Spending Accounts*.

If you decline benefits under the Partial Benefits Plan when you're first eligible, you may participate in an FSA if you later become eligible for the Full Benefits Plan and don't already have benefits under the Partial Benefits Plan.

During the annual open enrollment, you make your FSA election online for the following calendar year. You must re-enroll each year if you want to continue participating in an FSA the following year.

When and How You Can Change Participation

The election you make when you enroll in an FSA remains in effect for the entire calendar year. The only times you can change your elections—either begin, increase, decrease or stop contributions to an FSA—are:

- during the annual open enrollment for the following calendar year; and
- when you have a qualifying life event in the current calendar year.

To modify your FSA election when you have a qualifying life event, you must complete an online form within 30 days of the date of the qualifying life event.

When Participation Begins

The date your FSA begins depends on when you enroll:

- If you enroll in an FSA when you first become eligible for benefits, your FSA begins on the day your benefits begin, and you begin making contributions to your account through payroll deduction for the remainder of the calendar year. If you begin work on the first day of the month, your FSA begins on that day. If you begin work on any other day of the month, your FSA begins on the first day of the following month.
- If you enroll in an FSA because of a qualifying life event, your FSA becomes effective on the first day of the month following your qualifying life event and continues through the end of the calendar year. The amount you contribute to your account will be adjusted for the remaining payroll periods in the calendar year.

If you enroll online in an FSA during the annual open enrollment, you begin making contributions to your account with every paycheck in the next calendar year. Your FSA participation continues through December 31 of that calendar year.

When Participation Ends

Your participation in an FSA ends when you leave employment with the county and don't continue your benefits coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) or the retiree medical benefit.

However, when you take a leave of absence without pay and don't continue your benefits coverage, your participation is suspended temporarily until you return to work in a paid status. At that time, your participation will be resumed as long as your paycheck is large enough to cover the remaining deductions.

How to Continue Participation

You can continue participation in your health care and/or dependent care FSA when you:

- leave employment with the county;
- go on a leave of absence under the Family and Medical Leave Act (FMLA); or
- go on an unpaid leave of absence.

FSAs

King County offers two FSAs for all benefit-eligible employees:

- a **health care FSA**, which allows you to use before-tax dollars to pay for certain eligible expenses not covered by your medical, dental and vision plans (for example, copays for office visits, and the cost of orthodontia not fully paid by your dental plan); and
- a **dependent care FSA**, which allows you to use before-tax dollars to pay for eligible dependent day care expenses for your child, disabled spouse or other disabled dependents while you and your spouse work or look for work.

How FSAs Work

When you put money into an FSA, you don't pay federal income or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

When you decide to enroll in an FSA, it's very important that you estimate your eligible expenses as accurately as possible. The county allows you to be reimbursed only for expenses incurred in the calendar year of your FSA. You may request reimbursement from an FSA through March 31 of the following year for eligible expenses incurred during the calendar year. However, if FBMC, the FSA third-party administrator, doesn't receive your request by March 31, any funds left in your FSA after March 31 are forfeited, as required by IRS regulations.

Because health care and dependent care FSAs are separate accounts, the funds you allocate for one can't be used for the other, and you can't transfer dollars between accounts.

FOR MORE INFORMATION

For more information about how FSAs work, see "An Overview of FSAs" in *Flexible Spending Accounts*.

FOR MORE INFORMATION

For more information about how health care FSAs work, see "How the Health Care FSA Works" in *Flexible Spending Accounts*.

FOR MORE INFORMATION

For more information about how dependent care FSAs work, see "How the Dependent Care FSA Works" in *Flexible Spending Accounts*.

Health Care FSA

The minimum amount you may set aside for a health care FSA to pay for eligible expenses is $300, and the maximum amount is $6,000.

In general, health care expenses that would be deductible on your federal income tax return, excluding long-term care expenses, are eligible for reimbursement through the health care FSA.

Dependent Care FSA

The minimum amount you may contribute to a dependent care FSA is $300 per calendar year. The maximum amount you may contribute depends on your family situation, but the amount can't exceed $5,000.

To qualify for reimbursements from a dependent care FSA, you and your spouse must be at work or looking for work while your eligible dependents receive care. You must also meet certain eligibility requirements.

How to File a Claim

Health Care FSA

With a health care FSA, you may begin getting reimbursed from the FSA as soon as you incur eligible expenses in the FSA calendar year and your health care FSA reimbursement request has been received and approved. You're reimbursed for eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year.

Dependent Care FSA

With a dependent care FSA, you can get reimbursed for eligible expenses from the FSA only for amounts that are currently in your account. When future contributions are made to your account, you automatically receive another reimbursement until your total claim amount has been reimbursed or you reach your election amount for the calendar year.

Long-Term Disability (LTD) Insurance Plan

As a part-time transit operator, you receive county-paid basic long-term disability (LTD) insurance through CIGNA Group Insurance when you elect medical coverage for yourself in the Partial Benefits Plan. You also have the option to purchase CIGNA supplemental LTD insurance for yourself when you first qualify as a part-time transit operator, if you elect medical coverage. When you become eligible for the Full Benefits Plan, you automatically receive basic LTD insurance—you're not required to elect medical coverage.

Participating in the LTD Plan

To effectively use the LTD plan, you need to know who's eligible for the county's LTD insurance, when and how to enroll, when you can make changes, who pays for coverage, and when coverage begins and ends.

Who's Eligible

When you first qualify as a part-time transit operator, you're eligible to enroll in the Partial Benefits Plan and receive county-paid basic LTD insurance if you elect medical coverage for yourself. You're also eligible to purchase supplemental LTD insurance for yourself, if you elect medical coverage.

When you become eligible for the Full Benefits Plan, you automatically receive basic LTD insurance—you're not required to elect medical coverage.

When and How to Enroll

When you qualify as a part-time transit operator, you receive a Part-Time Local 587 New Hire Guide with benefit information and enrollment forms for the Partial Benefits Plan. If you elect medical coverage for yourself, you receive county-paid basic LTD insurance. You also have the option to purchase supplemental LTD insurance. To do so, you must return your benefit enrollment forms to Benefits and Retirement Operations within 31 days after the date your benefits begin.

If you don't purchase supplemental LTD insurance when you're first eligible, there are limited opportunities to purchase coverage later.

When and How You Can Change Coverage

The only change you can make to your LTD insurance is to discontinue supplemental LTD insurance, and you can discontinue coverage at any time. The reason you may discontinue supplemental LTD insurance is because you're paying for it.

If you wish to discontinue your supplemental LTD insurance, you need to submit a written request to Benefits and Retirement Operations or e-mail a request to kc.benefits@metrokc.gov.

After a qualifying life event, you may add basic LTD insurance coverage when you elect medical coverage, if you don't already have it. You can't add supplemental LTD insurance in either the Partial Benefits Plan or the Full Benefits Plan as a result of a qualifying life event.

Who Pays for Coverage

Because you're a part-time transit operator, your basic LTD insurance is paid by the county if:

- you're in the Partial Benefits Plan and elect medical coverage; or
- you're in the Full Benefits Plan.

FOR MORE INFORMATION

For more detailed information about participating in the LTD plan, see "Participating in the LTD Plan" in *Long-Term Disability Plan*.

If you elect supplemental LTD insurance, you pay a monthly premium based on a fixed amount. You pay your monthly premiums through payroll deduction.

The cost for supplemental LTD insurance is $3.96 a month.

When Coverage Begins

Coverage begins the first day of the month following your hire date, which is the first day you report to work, or your qualification date, whichever is later. If the later of your hire date or your qualification date is the first day of the month, your coverage begins the same day.

When Coverage Ends

Your coverage ends on:

- the last day of the month in which you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

LTD Plan

The LTD plan pays you a portion of your income when you're unable to work due to a disability.

How the LTD Plan Works

You become eligible for LTD benefits when you meet the plan's definition of "disability." Disability occurs if, because of injury or illness, you're unable to perform all the material duties of your regular occupation, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in your regular occupation. After 24 months, you're considered disabled if you're unable to perform all the material duties of any occupation, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in any occupation.

FOR MORE INFORMATION

For more detailed information about how the LTD plan works, see "The LTD Plan" in *Long-Term Disability Plan*.

How Benefits Are Calculated

CIGNA will calculate your LTD benefit based on your earnings on the last day you worked, as well as on other sources of income, such as workers' compensation, you're receiving at that time.

Basic LTD Insurance

Basic LTD insurance provides up to a total of 60% of all your predisability earnings after a 180-day benefit waiting period. If you return to work during or after your disability, the benefit can be as much as 100%. The maximum monthly benefit is $6,000.

Supplemental LTD Insurance

Supplemental LTD insurance provides up to a total of 60% of all your predisability earnings after a 90-day benefit waiting period. If you return to work during or after your disability, the benefit amount can be as much as 100%. The maximum monthly benefit is $7,200.

How Benefits Are Paid

After CIGNA receives and accepts proof of your disability, benefits are paid monthly. If you're not disabled for a complete month, an amount equal to $\frac{1}{30}$ of the LTD benefit is payable for each day that you're disabled.

How to File a Claim

If you're disabled and it seems likely your disability will last for the duration of the benefit waiting period, contact CIGNA by phone or through its Web site. You can submit a claim by phone or mail, or online. CIGNA must approve your claim before it is payable.

Life Insurance and Accidental Death and Dismemberment (AD&D) Insurance Plans

As a part-time transit operator, you may receive county-paid basic life insurance through Aetna Life Insurance and basic accidental death and dismemberment (AD&D) insurance through CIGNA Group Insurance. You also may be able to purchase supplemental life insurance and supplemental AD&D insurance for you and your eligible dependents.

IMPORTANT!

Certain limitations and exclusions may limit LTD benefits. (For more information about benefit limitations and exclusions, see "Understanding Exclusions and Limitations" in "The LTD Plan" in *Long-Term Disability Plan*.)

Participating in the Life Insurance and AD&D Insurance Plans

FOR MORE INFORMATION

For more detailed information about participating in the life and AD&D plans, see "Participating in the Life and Accident Plans" in *Life and Accident Protection*.

To effectively use your life and AD&D insurance plans, you need to know who's eligible for the county's life and AD&D insurance, when and how to enroll, when you can make changes, who pays for coverage, and when coverage begins and ends.

Who's Eligible

When you first qualify as a part-time transit operator, you're eligible to enroll in the Partial Benefits Plan and receive county-paid basic life and AD&D insurance if you elect medical coverage for yourself. If you elect medical coverage when you first qualify as a part-time transit operator, you're also eligible to purchase supplemental life and supplemental AD&D insurance for yourself and your eligible dependents.

When you become eligible for the Full Benefits Plan, you automatically receive basic life and AD&D insurance without electing medical coverage. You may elect supplemental AD&D insurance, but you're not eligible to elect supplemental life insurance because you didn't enroll when it was first offered to you as a part-time transit operator.

When and How to Enroll

When you qualify as a part-time transit operator, you receive a Part-Time Local 587 New Hire Guide with benefit information and enrollment forms for the Partial Benefits Plan. If you elect medical coverage for yourself, you receive county-paid basic life and AD&D insurance. You also have the option to purchase supplemental life and supplemental AD&D insurance. To do so, you must return your benefit enrollment forms to Benefits and Retirement Operations within 31 days after the date coverage begins. If you don't purchase supplemental life insurance when you're first eligible, you'll have limited opportunities to purchase coverage later on.

When and How You Can Change Coverage

When you have a qualifying life event, you may add, increase, decrease or drop supplemental life and supplemental AD&D insurance for you and your eligible dependents. However, you may add supplemental life and supplemental AD&D insurance for your eligible dependents only if you already have supplemental insurance for yourself.

If you aren't participating in the Partial Benefits Plan when a qualifying life event occurs, you may receive county-paid basic life and AD&D insurance by electing medical coverage for yourself because of the qualifying life event. By electing medical coverage, you may also elect supplemental life and supplemental AD&D insurance as a result of the qualifying life event.

The only change you can make at any time to supplemental life and supplemental AD&D insurance is to drop or decrease coverage—that's because you're paying for it.

To add or change supplemental life and supplemental AD&D insurance after a qualifying event, you must complete the appropriate form online within 31 days after the date your benefits begin.

If you wish to drop your supplemental life and/or supplemental AD&D insurance, you need to submit a written request to Benefits and Retirement Operations or e-mail your request to kc.benefits@metrokc.gov.

Who Pays for Coverage

If you're benefit-eligible, the county pays for your basic life and AD&D insurance; you pay for any supplemental insurance you purchase for you and your eligible dependents.

If you're benefit-eligible and on an unpaid leave of absence, you may pay for basic life and AD&D insurance, as well as any supplemental insurance you already have.

When Coverage Begins

Coverage begins on the first day of the month following your hire date or your qualification date, whichever is later. If the later of your hire date or qualification date is the first day of the month, your coverage begins the same day.

When Coverage Ends

Coverage ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

Your covered dependent's life and AD&D insurance also ends on the last day of the month your covered dependent enters into active full-time military service.

How to Continue or Convert Coverage

When you leave county employment, you may want to know your options for continuing and/or converting your life and AD&D insurance coverage.

Life Insurance

When you leave county employment for reasons other than disability, you may continue your existing life insurance or convert it to a whole life policy.

AD&D Insurance

Your AD&D insurance isn't portable. However, you may be eligible to purchase AD&D conversion insurance with CIGNA under certain circumstances.

FOR MORE INFORMATION

For more detailed information about how the life insurance plan works, see "Life Insurance Plan" in *Life and Accident Protection*.

Life Insurance Plan

Life insurance offers you and your family financial protection if a covered family member dies. You may also purchase supplemental life insurance for you and your eligible dependents to increase your coverage.

How the Life Insurance Plan Works

The life insurance plan includes:

- basic life insurance, which the county provides to benefit-eligible employees at no cost; and
- supplemental life insurance, which enables you to purchase additional coverage for you and your eligible family members.

If you elect supplemental life insurance for yourself and you die, your beneficiaries receive a benefit equal to the supplemental amount you've purchased **plus** your county-paid basic life insurance. If you elect supplemental life insurance for your eligible dependents, you're the beneficiary of supplemental life insurance if one of your covered dependents dies.

How Benefits Are Calculated

The amount of life insurance benefit you or your beneficiaries receive is based on your basic life insurance and, if you elected it, your supplemental life insurance.

Basic Life Insurance

If you're a part-time transit operator and you're in the Partial Benefits Plan and you elect medical coverage, or if you're in the Full Benefits Plan, you receive county-paid basic life insurance equal to $25,000.

Supplemental Life Insurance

You may purchase $25,000, $50,000, $75,000 or $100,000 in supplemental life insurance for yourself.

If you elect supplemental life insurance for yourself, you may purchase:

- 50% of the amount of your supplemental life insurance (without EOI) for your spouse/domestic partner; and
- $10,000 for each eligible child age 6 months to 23 years, and $500 for each eligible child age 14 days to 6 months. If you cover one child, all children are covered. EOI isn't required.

How Benefits Are Paid

Life insurance benefits can be paid at your death or the death of a covered dependent. Insurance is paid in a lump sum and isn't subject to federal income tax.

In the case of your or your covered spouse/domestic partner's terminal illness, certain benefits may be paid to you before death.

How to File a Claim

For a death or accelerated claim, you or your beneficiary should contact Aetna to file a claim. Benefits and Retirement Operations staff will help file the claim with Aetna, and provide referrals to counseling and other resources as requested.

AD&D Insurance Plan

The accidental death and dismemberment (AD&D) insurance plan pays benefits if you or a covered family member dies or suffers a specified dismemberment, paralysis and other loss that occurs within 365 days of a covered accident.

How the AD&D Insurance Plan Works

The plan includes:

- basic AD&D insurance, which the county provides to benefit-eligible employees at no cost; and
- supplemental AD&D insurance, which enables you to purchase additional coverage for yourself only or coverage for you and your family.

If you elect supplemental AD&D insurance for yourself and you die as the result of a covered accident, your beneficiaries receive a benefit equal to the supplemental amount you've purchased **plus** your county-paid basic AD&D insurance benefit. If you elect supplemental AD&D insurance for your eligible dependents, you're the beneficiary of supplemental AD&D insurance if one of your covered dependents dies as the result of a covered accident.

How Benefits Are Calculated

The amount of AD&D insurance benefit you or your beneficiaries receive is based on your basic AD&D insurance and, if you elected it, your supplemental AD&D insurance.

Basic AD&D Insurance

If you're a part-time transit operator and you're in the Partial Benefits Plan and you elect medical coverage, or if you're in the Full Benefits Plan, you receive county-paid basic AD&D insurance equal to $25,000.

Supplemental AD&D Insurance

You may purchase supplemental AD&D insurance from $50,000 to $500,000 in increments of $50,000 for yourself without evidence of insurability (EOI).

If you elect supplemental AD&D insurance for yourself, you may purchase:

- 50% or 100% of the amount of your supplemental life insurance for your spouse/domestic partner; and
- 10% of the amount of your supplemental life insurance for your eligible children.

FOR MORE INFORMATION

For more detailed information about how the AD&D insurance plan works, see "Accidental Death and Dismemberment (AD&D) Insurance Plan" in *Life and Accident Protection*.

Other AD&D Benefits

Supplemental AD&D insurance offers some benefits in addition to accidental death and dismemberment coverage. These benefits include a brain damage benefit, child care benefit, coma benefit, education benefit, felonious assault benefit, rehabilitation benefit, seatbelt/airbag benefit, secure travel benefit, special care benefit for children, and violent crime benefit.

How Benefits Are Paid

AD&D insurance benefits are payable if you or a covered dependent dies as the result of a covered accident. Insurance is paid in a lump sum and isn't subject to federal income tax. Be sure to consult your tax advisor for more information on taxes and death benefits.

How to File a Claim

For a death, specified dismemberment or paralysis claim, you or your beneficiary should contact Benefits and Retirement Operations. Benefits and Retirement Operations staff will help file the claim with CIGNA and provide referrals to counseling and other resources as requested. The claim should be filed within 90 days of the loss or death.